

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0034058</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Seminary Manor</u>		<b>I have examined the contents of the accompanying report to the</b> <b>State of Illinois, for the period from</b> <u>01/01/2002</u> <b>to</b> <u>12/31/2002</u> <b>and certify to the best of my knowledge and belief that the said contents</b> <b>are true, accurate and complete statements in accordance with</b> <b>applicable instructions. Declaration of preparer (other than provider)</b> <b>is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>2345 North Seminary</u> <u>Galesburg</u> <u>61401</u> Number City Zip Code		<b>Intentional misrepresentation or falsification of any information</b> <b>in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Knox</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>(309) 344-1300</u> <b>Fax #</b> <u>(309) 344-2473</u>		(Type or Print Name) <u>Ron Wilson</u>	
<b>IDPA ID Number:</b> <u>36-3114893007</u>		(Title) <u>Chief Financial Officer</u>	
<b>Date of Initial License for Current Owners:</b> <u>01/01/88</u>		(Signed) <u>See Independent Accountant's Report</u> (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		(Firm Name & Address) <u>117 E. Main St., Suite 210</u> <u>Galesburg, IL 61401</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(309) 342-1175</u> <b>Fax #</b> <u>(309) 342-7816</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Ron Wilson</u> <b>Telephone Number:</b> <u>(309) 343-1550</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number Seminary Manor# 0034058 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>121</u>	Skilled (SNF)	<u>121</u>	<u>44,165</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>121</u>	TOTALS	<u>121</u>	<u>44,165</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,487</u>	<u>5,524</u>	<u>3,255</u>	<u>11,266</u>	8
9	SNF/PED					9
10	ICF	<u>4,975</u>	<u>21,727</u>	<u>0</u>	<u>26,702</u>	10
11	ICF/DD					11
12	SC			<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,462</u>	<u>27,251</u>	<u>3,255</u>	<u>37,968</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 85.97%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/88

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 01/01/88 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 12 and days of care provided 3,255Medicare Intermediary AdminaStar Federal Inc.

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Seminary Manor

# 0034058

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	220,173	29,201	7,200	256,574		256,574		256,574		1
2	Food Purchase		299,444		299,444		299,444	(75,938)	223,506		2
3	Housekeeping	97,974	25,124		123,098		123,098		123,098		3
4	Laundry	49,634	24,530		74,164		74,164		74,164		4
5	Heat and Other Utilities			108,334	108,334		108,334	339	108,673		5
6	Maintenance	80,431	35,423	39,422	155,276		155,276	473	155,749		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	448,212	413,722	154,956	1,016,890		1,016,890	(75,126)	941,764		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,190,430	184,567	1,490	1,376,487		1,376,487		1,376,487		10
10a	Therapy			164,202	164,202		164,202		164,202		10a
11	Activities	68,169	4,168	929	73,266		73,266	(1,546)	71,720		11
12	Social Services	24,869			24,869		24,869		24,869		12
13	Nurse Aide Training			793	793		793		793		13
14	Program Transportation			279	279	908	1,187		1,187		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,283,468	188,735	182,693	1,654,896	908	1,655,804	(1,546)	1,654,258		16
	<b>C. General Administration</b>										
17	Administrative	93,102			93,102		93,102	81,511	174,613		17
18	Directors Fees										18
19	Professional Services			171,198	171,198		171,198	(150,642)	20,556		19
20	Dues, Fees, Subscriptions & Promotions			37,243	37,243		37,243	(25,390)	11,853		20
21	Clerical & General Office Expenses	47,108	23,786	22,516	93,410		93,410	8,364	101,774		21
22	Employee Benefits & Payroll Taxes			340,653	340,653		340,653	15,439	356,092		22
23	Inservice Training & Education			1,403	1,403		1,403		1,403		23
24	Travel and Seminar			1,100	1,100		1,100	8,757	9,857		24
25	Other Admin. Staff Transportation			1,815	1,815	(908)	907		907		25
26	Insurance-Prop.Liab.Malpractice			69,426	69,426		69,426	595	70,021		26
27	Other (specify):* See Attached Sch VI			2,196	2,196		2,196	(2,196)			27
28	<b>TOTAL General Administration</b>	140,210	23,786	647,550	811,546	(908)	810,638	(63,562)	747,076		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,871,890	626,243	985,199	3,483,332		3,483,332	(140,234)	3,343,098		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Seminary Manor

#0034058

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			122,918	122,918		122,918	56,702	179,620			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							55,202	55,202			32
33	Real Estate Taxes			118,726	118,726		118,726	287	119,013			33
34	Rent-Facility & Grounds			591,888	591,888		591,888	(587,900)	3,988			34
35	Rent-Equipment & Vehicles			5,663	5,663		5,663	259	5,922			35
36	Other (specify):* Amortization											36
37	<b>TOTAL Ownership</b>			839,195	839,195		839,195	(475,450)	363,745			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,575	7,575		7,575		7,575			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,247	66,247		66,247		66,247			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			73,822	73,822		73,822		73,822			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,871,890	626,243	1,898,216	4,396,349		4,396,349	(615,684)	3,780,665			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor

# 0034058

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(74,423)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(23,011)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,515)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,615)	27		24
25	Fund Raising, Advertising and Promotional	(25,976)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(132)	20		28
29	Other-Attach Schedule See Att Sch VII	(2,127)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (128,799)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense		31	33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(486,885)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (486,885)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (615,684)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Seminary Manor

ID# 0034058

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Seminary Manor

# 0034058

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(75,938)	0	0	0	0	0	0	0	0	0	0	(75,938)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(75,938)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(75,938)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(26,953)	0	0	0	0	0	0	0	0	0	(26,953)	19
20	Fees, Subscriptions & Promotions	(26,108)	0	0	0	0	0	0	0	0	0	0	(26,108)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,615)	0	0	0	0	0	0	0	0	0	0	(1,615)	27
28	<b>TOTAL General Administration</b>	<b>(27,723)</b>	<b>(26,953)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(54,676)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(103,661)</b>	<b>(26,953)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(130,614)</b>	<b>29</b>

## Summary B

12/31/2002

[illegible]



Facility Name & ID Number      Seminary Manor      # 0034058      Report Period Beginning: 01/01/2002      Ending: 12/31/2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
RFMS, Inc (100% owned by Don Fike)	100	See Attached Schedule I		RFMS, Inc	Galesburg	Admin Services
				Donald E. Fike	Galesburg	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	34 Facility Rental	591,888	Donald E. Fike	None	131,956	(459,932)	2
3	V							3
4	V							4
5	V	19 Administrative Services	156,000	RFMS, Inc. (100% Don Fike owned)	None	129,047	(26,953)	5
6	V							6
7	V							7
8	V							8
9	V			See Attached Schedules III and IV				9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 747,888			\$ 261,003	\$ * (486,885)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number      Seminary Manor      #      0034058      Report Period Beginning:      01/01/2002      Ending:      12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Don Fike	President	Management	100.00	See attached	> 40	100.00	Salary	\$ 8,861	17-7	1
2					Schedule III			Benefits	372	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,233		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0034058 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2	Bank One Springfield		X	Refinanced Bldg Mortgage	Varies pd	05/09/96	2,140,357	736,702	04/01/11	6.6600	55,197		2
3					Quarterly								3
4	Interest Income Adjustment			From page 5, line 10									4
5													5
	Working Capital												
6													6
7	Miscellaneous vendors		X	Miscellaneous operating									7
8	Home Office Allocation Adj			See Attached Schedule III							5		8
9	TOTAL Facility Related						\$ 2,140,357	\$ 736,702				\$ 55,202	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$ 2,140,357	\$ 736,702				\$ 55,202	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None      Line #           

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)      SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

### B. Real Estate Taxes

[illegible]

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Seminary Manor COUNTY Knox  
FACILITY IDPH LICENSE NUMBER 0034058  
CONTACT PERSON REGARDING THIS REPORT Ron Wilson  
TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

## B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

## X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 42,680 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1
- C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

Seminary Estates Retirement Apartments 74 units 66,317 square feet

Hawthorne Inn Assisted Living Facility 68 beds 32,843 square feet

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

## A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	4.33 acres	1990	\$ 18,000	1
2					2
3	TOTALS			\$ 18,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Seminary Manor

# 0034058

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	121		1987	\$ 2,157,612	\$ 68,496	31	\$ 68,496		\$ 1,053,126
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	<b>Total improvements by year constructed:</b>								
10	1988		1988	251,153	7,973	12 to 31	7,904	(69)	113,150
11	1989		1989	9,773	310	31	310		4,340
12	1990		1990	7,328	391	5 to 31	49	(342)	6,409
13	1991		1991	25,242		6			25,242
14	1992		1992	16,377	967	10 to 15	950	(17)	13,361
15	1993		1993	1,515	89	7		(89)	1,400
16	1994		1994	10,485		15	699	699	6,174
17	1995		1995	16,200	467	7 to 25	897	430	6,863
18	1996		1996	19,543	1,121	7 to 25	1,420	299	9,027
19	1997		1997	16,313	1,203	10	1,632	429	9,207
20	1998		1998	5,522	142	39	142		668
21									
22	<b>Detailed improvements for the years 1999-2002:</b>								
23	Sidewalks		1999	3,024	233	15	202	(31)	758
24	Garage		1999	9,546	735	15	636	(99)	2,120
25	Fence		1999	16,292	1,006	20	815	(191)	2,717
26	Roof repair		2001	11,295	2,033	10	1,130	(903)	1,601
27	Remodeling-construction		2001	25,381	2,411	15	1,692	(719)	2,397
28	Remodeling-design		2001	4,572	1,463	5	914	(549)	1,295
29	Remodeling-flooring		2001	122,335	22,020	10	12,234	(9,786)	17,332
30	Remodeling-wallpaper		2001	10,735	3,435	5	2,147	(1,288)	3,042
31	Remodeling-equipment		2001	3,200	1,024	5	640	(384)	907
32	Remodeling-painting		2001	74,583	23,867	5	14,917	(8,950)	21,132
33	Doors		2002	4,911	327	10	450	123	450
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT



B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$    2,822,937	\$    139,713		\$    118,276	\$    (21,437)	\$    1,302,718	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 814,002	\$ 49,517	\$ 44,141	\$ (5,376)	5 to 15	\$ 571,999	71
72	Current Year Purchases	23,717	3,692	2,522	(1,170)	3 to 10	2,522	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Schedule III)		2,954	2,954				74
75	TOTALS	\$ 837,719	\$ 56,163	\$ 49,617	\$ (6,546)		\$ 574,521	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Dodge Caravan	1999	\$ 15,564	\$ 1,793	\$ 3,113	\$ 1,320	5	\$ 11,933	76
77	Patient Care	1999 Ford Bus	1999	43,070	4,962	8,614	3,652	5	33,020	77
78										78
79										79
80	TOTALS			\$ 58,634	\$ 6,755	\$ 11,727	\$ 4,972		\$ 44,953	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,737,290	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,631	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,620	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,011)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,922,192	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**If NO, see instructions.**

☒ YES ☐ NO

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE _____	
	HOURS PER AIDE _____		

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 448	\$	\$ 448
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 448	\$	\$ 448
10	SUM OF line 9, col. 1 and 2 (e)	\$ 448			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>1</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>1</u>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Seminary Manor

# 0034058

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 74,692	\$ 362,902	1
2	Cash-Patient Deposits	2,202	2,202	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	326,122	831,854	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,163	34,337	6
7	Other Prepaid Expenses	175	175	7
8	Accounts Receivable (owners or related parties)		309,474	8
9	Other(specify): <a href="#">See Attached Schedule VIII</a>		6,663	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 430,354	\$ 1,547,607	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		90,302	12
13	Land		18,000	13
14	Buildings, at Historical Cost		2,443,147	14
15	Leasehold Improvements, at Historical Cost	379,792	514,602	15
16	Equipment, at Historical Cost	609,259	1,608,004	16
17	Accumulated Depreciation (book methods)	(542,700)	(2,702,420)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">Loan Financing Costs</a>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 446,351	\$ 1,971,635	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 876,705	\$ 3,519,242	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 111,856	\$ 145,222	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,202	2,202	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,447	1,332,812	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	2,798	2,798	31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,500	119,680	32
33	Accrued Interest Payable		4,052	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">Interdivision Payable</a>			36
37	<a href="#">Other Accrued Liabilities</a>			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 394,803	\$ 1,606,766	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		736,702	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">Resident Security Deposits</a>	82,283	82,283	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 82,283	\$ 818,985	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 477,086	\$ 2,425,751	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 399,619	\$ 1,093,491	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 876,705	\$ 3,519,242	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 526,999</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Year-end adjustments made subsequent to the filing of the</b>		<b>3</b>
<b>4</b>	<b>prior year's Medicaid cost report. (See Attached Schedule IX)</b>		<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 526,999</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>693,420</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 693,420</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Interdivision transfers</b>	<b>(820,800)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$ (820,800)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 399,619</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,932,975	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,932,975	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,315	6
7	Oxygen	7,297	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 72,612	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,093	13
14	Non-Patient Meals	74,423	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	568	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 80,084	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	847	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 847	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>	1,546	28
28a	<b>Durable Medical Equipment</b>	1,705	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,251	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,089,769	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,016,890	31
32	Health Care	1,654,896	32
33	General Administration	811,546	33
<b>B. Capital Expense</b>			
34	Ownership	839,195	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,575	35
36	Provider Participation Fee	66,247	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,396,349	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	693,420	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 693,420	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number Seminary Manor# 0034058Report Period Beginning: 01/01/2002Ending: 12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,097	1,167	\$ 21,310	\$ 18.26	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	6,670	7,096	109,562	15.44	3
4	Licensed Practical Nurses	22,580	24,021	302,185	12.58	4
5	Nurse Aides & Orderlies	73,695	78,399	638,950	8.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	2,007	2,135	25,616	12.00	9
10	Activity Assistants	6,667	7,092	42,553	6.00	10
11	Social Service Workers	1,670	1,776	24,869	14.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,547	30,369	220,173	7.25	15
16	Dishwashers					16
17	Maintenance Workers	7,763	7,726	80,431	10.41	17
18	Housekeepers	13,372	14,120	97,974	6.94	18
19	Laundry	7,394	7,866	49,634	6.31	19
20	Administrator	1,956	2,080	66,725	32.08	20
21	Assistant Administrator	1,779	1,892	26,377	13.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,680	4,979	47,108	9.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,846	1,964	15,708	8.00	31
32	Other Health Care Supervisors	9,248	9,839	102,715	10.44	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,971	202,521	\$ 1,871,890 *	\$ 9.24	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	***	\$ 7,200	1-3	35
36	Medical Director	***	15,000	9-3	36
37	Medical Records Consultant	***	0	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	1,440	10-3	39
40	Physical Therapy Consultant	***	79,462	10a-3	40
41	Occupational Therapy Consultant	***	63,784	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	20,956	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) Dental Consultant	***	50	10-3	46
47	Psychological Consultant	***		10-3	47
48	***=Monthly Fee Arrangement				48
49	TOTAL (lines 35 - 48)		\$ 187,892		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Linda Leafgreen	Administrator	None	\$ 66,725	Workers' Compensation Insurance		\$ 50,062	IDPH License Fee	\$ 400	
Barbara Benton	Asst. Admin.	None	26,377	Unemployment Compensation Insurance		28,097	Advertising: Employee Recruitment	2,012	
				FICA Taxes		140,293	Health Care Worker Background Check (Indicate # of checks performed <u>50</u> )	1,202	
				Employee Health Insurance		104,082	<u>IHCA Dues</u>	6,113	
				Employee Meals			Subscriptions & Fees	1,372	
				Illinois Municipal Retirement Fund (IMRF)*			<u>Other Licenses</u>	36	
				<u>401(k) Plan Contributions</u>		11,437	<u>Advertising - Promotional</u>	25,976	
				<u>Other Employment Benefits</u>		4,187	<u>Advertising - Yellow Pages</u>	132	
				<u>Employee Appreciation</u>		2,495	<u>Indirect Costs - See Attached Sch III</u>	718	
							Less: Public Relations Expense	(	
							Non-allowable advertising	(25,976)	
							Yellow page advertising	(132)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,102				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,853	
B. Administrative - Other				Indirect Costs - See Attached Sch. III					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 356,092			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
RFMS, Inc.	Administrative Services		\$ 156,000				Out-of-State Travel	\$	
McGladrey & Pullen, LLP	Accounting Services		6,505						
Davis & Campbell	Legal Fees		7,900						
Blake Law	Legal Fees		369				In-State Travel	226	
Crain, Miller & Associates	Legal Fees		424				<u>Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)</u>	874	
							Seminar Expense		
							<u>Less out-of-state training</u>		
							<u>Indirect Costs - See Attached Sch. III</u>	8,757	
							Entertainment Expense	(	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 171,198	TOTAL		\$	TOTAL	\$ 9,857	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	None												
3													
4													
5													
6													
7													
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9													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See page 21 Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,924 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 66,247  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 74,423
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.